

EDITORIALS

Avicenna Revisited

AMONG THE DESPERATE NEEDS of the underdeveloped countries, health care ranks high. Health care is here used in its broadest sense to include personal treatment for disease, preventive medicine (insofar as we understand that attractive phrase) and the innumerable variables that may be grouped as public health. In many countries it also includes birth control, as numbers press upon resources in marginal Malthusianism. The problems of health merge into the domains of sociology, economics, education and governance, and cannot be easily circumscribed by boundaries of disciplines or of countries. The World Health Organization was established for the simple reason that problems of health are common to all countries, although regional silhouettes of disease frequencies may vary greatly.

The United States has played an important but uneven role in international health. Individual persons, private institutions (notably the Rockefeller Foundation) and governmental agencies have assisted directly or have lent major support to international programs. The results of biomedical research have universal application, so that the National Institutes of Health are actually international in their relevancy. Also, the United States has become a Mecca for medical education, attracting many of the best young physicians from around the world into its postgraduate programs for clinical and research training. It is this latter phenomenon that has been ambiguous in its effect. We can be proud that many of the physicians and medical educators, and those in other health disciplines who hold positions of great responsibility in foreign countries, have received their educations in our institutions. We cannot be proud of the overwhelmingly positive balance in talent trade which has occurred as a by-product of this educational exchange. FMG (foreign medical graduate) is an abbreviation around which swirls a confused array of emotional and political forces, largely motivated by parochial considerations of what is perceived as best for American medicine. Less attention has been directed to the effect that this massive migration of trained professionals may have had on their respective coun-

tries of origin. The net immigration of foreign physicians seems likely to be sharply curtailed in the future due to changes in our immigration policy, the increasing competition from United States graduates for limited positions, and in some cases by restrictions on freedom of emigration of physicians by their respective countries. As an unfortunate by-product the forces which will reduce immigration also tend to limit access of foreign health professionals to the best in American postgraduate medical education. It is therefore imperative that developing countries look to their own resources for postgraduate education and research. Iran is a country that is attempting to make this transition.

Iran has a recorded history of 2,500 years. Its earliest university, the Jondi Chapour university, was founded 1,700 years ago during the Sassanid dynasty as a center of higher learning in medicine, philosophy and pharmacology. Avicenna (980 to 1037) was one of the distinguished physicians of antiquity. His *Canon of Medicine* was the forerunner of present textbooks of medicine and was widely used in Europe for centuries. During those centuries Persian education declined and as recently as 50 years ago there was no university in Iran. At present Iran shares many of the problems of developing nations in its health care. Some 40 percent of Iranian physicians live in Tehran, which contains 12 percent of the nation's population of 35,000,000. The great majority of other Iranian physicians live in the next five largest cities. There are now eight medical schools in Iran and seven more will be established within the next two years. The present number of graduates is about 700 annually, but this number will double within the next decade. Facilities for postgraduate education and biomedical research are notably limited. Pahlavi University Faculty of Medicine in Shiraz has had the strongest academic program in medicine and the medical sciences as judged by Western standards. A recent survey showed a net emigration of 50 percent of its graduates to the United States (two thirds came here for training and approximately two thirds of those remained permanently). It is estimated that more

than 3,000 Iranian physicians now live in the United States. Meanwhile many of Iran's problems in health care continue to be inadequately addressed.

Iran is more fortunate than most developing countries. In addition to its long cultural heritage, it now has the resources to undertake new initiatives in health care and health education. One such initiative is the establishment of the Imperial Medical Center of Iran (IMCI) now under construction in Tehran. A consortium of medical schools—Columbia, Cornell and Harvard—was involved in advising about the organization and development of this major academic health science center. An international Board of Governors, representing these and other American medical schools, continues to advise the Director, Abdol Hossein Samii, concerning academic policy. As presently projected the IMCI will undertake a number of activities more or less simultaneously. Its educational activities will include (1) a medical school with a strong science base tilted toward the training of academic physicians as well as practitioners, (2) a graduate school of biomedical sciences for the doctoral degree, (3) an undergraduate and graduate school of nursing, (4) a school for allied health professionals, (5) a school of health planning management and (6) a strong program for housestaff and specialty training. An important development has been the establishment of the Pahlavi Library of Medicine and Biomedical Communications Center, already operating in Tehran and linked to the National Library of Medicine via satellite. This library has been designated as the World Health Organization's regional library for the Middle East and Eastern Mediterranean region. An Institute of Continuing Education is being established which is of particular importance in a country with isolated facilities, comparatively poor communications and uneven levels of professional competency. The research programs envisioned at the IMCI will be in most of the traditional disciplines but there will be an attempt to give special emphasis to problems of special pertinence not only to Iran but to Third World nations in general: infectious disease, nutrition, population control, public health and health care delivery. The realization of these ambitious plans in the next few years should also establish the IMCI as a center for tertiary care in Iran and the Near East.

Is this a wise investment of Iranian resources? Certainly it would not be so if the building of a

model academic center in Tehran were the only major investment made by the government to improve the health care of the Iranian people. The problems that must be faced in providing health care in Iran are multiple and complex. The IMCI will help solve some, but by no means all of them. IMCI will succeed only to the extent that it is a resource for training and research to meet the pressing problems of improving the quality of and the access to health care in Iran. It will be one important component of a solution and as such deserves the attention and assistance of American medicine. As this talented and ambitious people develop their own resources in health care, other nations may benefit on regional and international levels as well. They did so in the time of Avicenna. Why not now again 1,000 years later?

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Trends in the Science and the Art

THERE ARE SIGNS that we may be approaching a need for some change in medical practice as we have known it in the last few decades. On the one hand physicians have increasingly held to the premise that everything that is important in patient care must have a scientific basis, and if it does not it is not important. On the other hand a growing segment of the public, and many professionals and would-be professionals, are becoming dissatisfied with the care they are receiving at the hands of scientific doctors and are seeking care, even relief, elsewhere. Scientific medicine is sought and given its due when there is something that can be fixed, but often, perhaps even more often, there is a void of need which scientific medicine does not fill, and indeed may never be able to fill.

One senses two distinct social trends. One is to reduce or eliminate what is not scientific in patient care. The other is a growing search for and acceptance of alternative methods of care which may or may not have any scientific basis. The first trend seems motivated both by a laudable desire to rid scientific patient care of its impurities and possibly also by a desire to control costs. Donald Kennedy, Commissioner of the Food and Drug Administration, is in the forefront of this trend having recently said "No drug should be